THE OBSTETRICAL SOCIETY OF SAN FRANCISCO: A REMINISCENCE

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When first I came to San Francisco I was asked to become a member of the San Francisco Obstetrical Society, not because I was interested in obstetrics but because I was then working at pathology. Previous to my joining, it had fallen into desuetude, and the reason for this was characteristic and amusing. One of the most prominent men in diseases of women of that day, was an able, bad-tempered Irishman, who managed to quarrel wtih everyone in the same line of work as himself. On his demise the secretary sent out notices of his death saying that there would be a meeting to frame condolences to the family, and at the same time measures would be taken to resuscitate the society. Subsequent to this propitious reopening announcement, we had many pleasant gatherings, and the crowning point of the evening was always the supper, and at one of these the late Dr. Harry Gibbons told the following story:

A traveler, while crossing the prairie in the great Southwest, became constipated, a not unusual eventuality with travelers. There were no towns, and dwellings were scarce and drug stores were not even to be hoped for. Finally he reached a wretched shack on the plains, but none of the men were at home. The traveler's condition became so desperate that he finally asked the sole occupant of the dwelling, a woman, if she knew of any relief. "Oh yes!" she said as she handed him a lead musket ball, "Swallow that, but be sure not to lose it. It has been in the family a long time."

This is not the first time this primitive means of alleviation has appeared in medical literature. It is mentioned by Burton in his charming book, "The Anatomy of Melancholy," a book which Samuel Johnson used to say was the only one that ever got him out of bed an hour before his usual time of arising.

The Obstetrical Society was composed of a remarkable group of men, shrewd and able in their work. Clinton Cushing was the foremost abdominal surgeon of his day on the Coast, and would have made his mark in any country. George Chismore was leaving gynecology, in which he had made a local reputation, and was entering genito-urinary surgery, in which he was to make a national reputation. Charles Blake and Wagner, whom we used to call "Wagner of the Mission," were excellent, trustworthy practitioners, and W. F. McNutt was then at the height of his very large practice. I was then a young fellow, fresh from the laboratories and large clinics of Europe, and the men composing the Society were large enough and open-minded enough to receive what I had to impart. I, on the other hand, had much to learn from them of things that no laboratory would or could teach. In many ways the practice of medicine is like hunting. The causes of diseases are multitudinous, and are as elusive and deceptive as the most cunning of game animals. The hunter's patience and observation of general and particular details, find excellent employment by the physician. Furthermore, the broad general lines of medicine remain the same *in saecula saeculorum;* and, most important of all, the practice of medicine has always been better than the theories which seem to govern it.

Most of the men composing the Society were from the Middle or Eastern States and they had many a tale to tell, similar to that of Doctor Gibbons above related, pertaining to the era of primitive medicine that preceded in this country the establishment of the Johns Hopkins Hospital.

Doctor Cushing, I believe, graduated from Jefferson College and at first moved out to Ohio, which was then out west. At one of our suppers he told the following, illustrating the shrewdness and resourcefulness of the backwoods doctor:

It was a case of retarded labor. The head refused to engage in the pelvis, and the young doctor in attendance, a graduate of a reputable institution, was desperate. The family asked him if he would consult with an elderly practioner of the neighborhood and he assented.

After seeing the patient they retired to a log in the back-yard to consult. After whittling a little with his jack-knife, and copiously expectorating, the old man said. "Well, doctor, I'd quill her." The doctor acknowledged that he did not know what "quilling" meant. The old man showed him. He took a large goose quill, and cut off the very tip. With this he had a catheter with a rounded point, which he introduced into the bladder, and drew off the urine.

As a further explanation of the above incident it must be remembered that between the old apprentice system and the present practical system, there was an interval in medical teaching in this country in which the student did not get any practical instruction, even in mid-wifery, and that the young man mentioned in the story was not to be blamed for not recognizing the cause of the retarded labor.

Shortly ago, on a visit to Chicago, I related this story to Dr. W. A. Pusey. I said that I did not know of what other material a catheter could have been improvised. He then told me that in one of his visits to the country a man showed him a catheter made from an umbrella rib. These ribs are grooved. The man cut a rib square off, and then fashioned a tip out of lead, which he attached to it. This, the inventor said, gave satisfactory results, as, on the instrument being introduced, the urine trickled down along the groove as in a gutter.

Doctor Cushing had a remarkable career. When the war of the rebellion broke out, although he was in the United States service on active duty, he did not know of the disturbance until it was well along in its third year, and approaching its end. He had joined the American

Navy, and was on a vessel stationed off the mouth of the Congo, watching for slavers. Afterwards, for years, he enjoyed a large general practice in Oakland. When past the acme of life, he was appointed Professor of Gynecology in the Lane School of Medicine, and visited the European clinics, especially those of England. At a time when, because of the new antiseptic methods, the older men in surgery were going down like ninepins in a bowling alley, he swept forward to becoming the chief abdominal surgeon on the Pacific Coast. Besides his age, he had yet another handicap. Medicine, and principally surgery, is much dependent upon commerce for its eminence. As a rule the large commercial centers are also the medical centers. San Francisco in 1886 was declining; Portland, Seattle and Spokane on the North, and Los Angeles in the South were cutting into its trade. In spite of this Cushing's sphere of influence for many years grew wider and wider.

Chismore was another example of a man changing his work late in life. As a boy he was a sailor, then a miner, then a dentist, and then a contract army surgeon. After leaving the army he took his degree in the Lane Medical College and entered general practice, leaning decidedly toward gynecology. Fortunately, through medical politics, he lost his place in the California Hospital for Women, and then bent his energies to genito-urinary diseases, in which he achieved a great and deserved success. A gentler, more honest, more straightforward nature never existed. His tales of his early life in Alaska were the delight of every company he was in, and were the especial delight of that charming story teller, Robert Louis Stevenson.

Everything has its terminus, even medical societies, and the Obstetrical Society of San Francisco was no exception. The men either lost interest or dropped out, or other societies and combinations engaged their attention. Doctor Cheney says that the finishing touch was the Last Supper given in my home; it may be he is right. At any rate the society passed into history a good many years ago, not, however, without having furnished much in instruction and much pleasure to its members.

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ABDOMINAL WAR WOUNDS.*

By REA SMITH, M. D., Los Angeles.

Penetrating wounds of the abdomen causing visceral injury were as a rule fatal on account of the lack of transport, and delays in getting the patient to the operating table. At Evacution Hospital No. 114, we received patients from 6 to 72 hours after being hit. Many of the cases with abdominal wounds were moribund either from hemorrhage or from peritonitis already well developed.

If any one change could be suggested to better conditions in war for men with abdominal wounds, it would be a special line of transportation, with rapid passage through forward stations and treillage.

Machine gun bullet wounds were usually from the front, and the patients were not unlike the patients that we are all accustomed to see in the accident surgery of civil life. It is not my purpose to take up your time with wounds of the solid viscera, which it was necessary to treat there as here with due regard to hemorrhage shock.

Intestinal perforations were as a rule multiple. Our policy was to do as little surgery as possible; rapidly sewing up the perforations and resecting only when absolutely necessary on account of damaged circulation or extensive injury to the intestinal wall. It was necessary, however, to search carefully for all wounds in the intestines, and not be satisfied by finding and closing one or two.

Wounds made by shell fragments were usually in the back, as soldiers dropped on their faces when they heard a shell in the air or when their position was being shelled. The greatest surprise was at the frequency with which the shrapnel was arrested and turned in its course by the parietal peritoneum. It was the rule rather than the exception to find that shrapnel had gone to the peritoneum and been deflected by it, rather than that it had gone straight through. I saw several cases in which the missile had gone through the ileum, carrying a block of bone its own size and shape with it, and had then been deflected down into the pelvis without wounding either the peritoneum or bladder.

These wounds were accompanied by a retroperitoneal hematoma, usually dissecting and extensive, and I think on that account largely the differential diagnosis between penetrating or non-penetrating wound was made most difficult.

The peritoneal irritation incident upon its being loosened from its attachment and stretched by accumulated blood, gave all the signs of peritoneal irritation due to infection. We had rigid muscles of the anterior wall with great tenderness, and the peritoneal snap in the pulse.

Add to that the localization of the foreign body by the X-ray at a point that is palpably intra-abdominal, but that has become extra peritoneal by the encroachment of the hematoma on the peritoneal cavity, and dullness in the flank due to the confined blood, and a picture is presented that will force almost any abdominal surgeon to open in front. Many of these patients were opened and clean peritoneal cavity found. The added shock of laparotomy did not help the patient's chances of recovery. While it was a simple procedure to excise the wound of entrance, remove the foreign body if quickly available, if not to drain the wound, and make the patient safe for transportation, and more careful study at the base.

I did not think it possible to have signs and symptoms of visceral abdominal injury simulated so closely by any extra peritoneal lesion, as I saw over and over again. And I have presented this small paper to you to make that one point that may or may not be of value to you at some time in the surgery of civil life.

*Read before the Forty-eighth Annual Meeting of the Medical Society, State of California, Santa Barbara, April, 1919.